



MARCH 2016

Integrating Public Health and Health Care: *Getting Beyond the Theory*

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Introduction

Historically, state purchasers of health care, such as Medicaid and state employee group plans, have seldom worked closely with state, county and local public health officials. Without economic incentives, health plans and providers had little reason to consider the implications of population health.

The movement toward population-based payment models in health care delivery is changing this dynamic. These new payment models are designed to financially reward providers and entities for improvements in population health status. Under such alternative payment arrangements, providers have reasons to think more broadly about the health of populations in the geographic areas they serve. As health care providers assume risk for total cost of care, it becomes increasingly important for providers to consider ways to address social and other non-medical drivers of health, and to employ upstream prevention strategies to reduce the incidence of illness and injury. Emerging integrated delivery system models, such as accountable care organizations (ACOs), are providing financial incentives to support health promotion and other aspects of public health in order to contain costs, improve care, and enhance health status. While the public health infrastructure varies across states and localities, adequately-resourced health departments possess important community-level data and expertise that are assets for risk-bearing provider organizations seeking to improve population health.

In addition, the federal government, through State Innovation Model (SIM) grants¹ and Medicare payment reform initiatives, is creating opportunities for the entire health system to embrace more holistic approaches for keeping populations healthy.

Integrating public health and health care helps foster a better understanding of the health needs of a population among public health practitioners and providers of clinical services and the ways in which each of these disciplines can improve health status. Together, the two sectors can establish a set of population health priorities and target their resources to achieve agreed-upon objectives.

ABOUT STATE HEALTH AND VALUE STRATEGIES

State Health and Value Strategies, a program funded by the Robert Wood Johnson Foundation, provides technical assistance to support state efforts to enhance the value of health care by improving population health and reforming the delivery of health care services. The program is directed by Heather Howard at the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org.

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This brief examines practical approaches state agencies might employ to better integrate public health and health care delivery as a means of improving health and the value of health care. The brief is organized according to seven features of integration:

1. Coordination Agreements and Mechanisms
2. Shared Governance
3. Financing and Payment Models
4. Coordinated Analysis and Program Planning
5. Provider Recognition and Marketing
6. Development and Implementation of Clinical Tools and Resources
7. Provider Training and Technical Assistance

These integration features are not mutually exclusive, some programs and approaches may contain more than one feature related to the integration of public health and health care.

For the purposes of this brief, “public health integration” is broadly defined as a relationship(s) between public health officials and a health care organization (e.g., an ACO) that aim(s) to strengthen the connection between clinical processes or the delivery of health care, and public health prevention efforts. Integration enables public health officials and clinical providers to combine efforts, resources, and expertise to achieve a shared goal of improving the health of populations. However, as noted by the Institute of Medicine (IOM), interactions between health care and public health sectors are “so varied and dependent on local circumstances, such as the availability of resources and differences in health challenges, that it is not possible to prescribe a specific model or template for how integration should look.”² Regional dynamics will necessarily influence the degree and mechanism(s) of integration. Attached case studies³ provide more detail related to some of the examples cited in this Brief.

1. Coordination Agreements and Mechanisms

Public health agencies and health care providers can enter into informal or formal written agreements to broadly coordinate their efforts. For example:

- The state of Oregon requires its Coordinated Care Organizations (CCOs), regional health systems that manage care for Medicaid beneficiaries, to have written agreements with local public health authorities to collectively develop and promote

strategies to improve the health of the regions they serve.⁴

- Louisiana’s Medicaid managed care organizations are required to coordinate with the Office of Public Health (OPH) on outreach activities that meet the state’s public health priorities, and they must negotiate coordination mechanisms and operational protocols with OPH and Medicaid.⁵

2. Shared Governance

Integrating public health and health care services through a formal governance structure creates opportunities for the traditionally siloed functions to develop shared goals, consider comprehensive intervention strategies, and identify ways that their services can be complementary. In addition, shared governance is a way of raising awareness of public health resources and functions among clinical providers.

One way to create such a structure is for health care providers to include public health representative(s) on a governing entity’s board, providing public health officials with a meaningful role in directing the board’s strategies and priorities. The board’s governance documents may also include a commitment to engaging with the state or county public health department to implement prevention initiatives aimed at improving the health of its members and the broader community. As part of the governing body, public health officials are positioned to play an important role in helping providers think about longer-term returns on investment in primary and secondary prevention.

- In [Lane County, Oregon](#), the county public health department manages the CCO’s community advisory council, bringing together local experts, scientists, community leaders, and Medicaid beneficiaries to identify and recommend evidence-based preventive medicine proposals for the CCO board’s consideration and final approval.⁶ Two community advisory council members are also voting members of the CCO board, enabling them to advocate for the proposed public health strategies.

3. Financing and Payment Models

Health care providers or health plans can invest financially in public health infrastructure to support stronger connections between public health and health care delivery. Direct investment in public health by providers and/or plans affords them more influence on the health status of the population for which they are held accountable. It may

also provide a more sustainable funding stream for public health programs. Financial investment may take the form of a direct payment from a health care entity to a state or county public health department to support staffing or specific prevention programs.

- In Oregon, [Trillium Community Health Plan](#) pays a per-member-per-month amount to the county's health and human services department to fund three staff positions and public health activities that are authorized by the CCO's board. One of the staff manages the community advisory council and another leads the implementation of approved prevention initiatives.⁷
- In Colorado, Rocky Mountain Health Plans reinvests a percentage of its annual revenues to support community wellness initiatives, including a partnership with the Colorado Department of Public Health and the Environment to implement a practice-based childhood obesity program.^{8,9}

4. Coordinated Analysis and Program Planning

State and county public health departments manage population-based statistics and data that can be useful for health care entities or providers who are planning community-based health promotion programs. Epidemiologists analyzing population health data may detect gaps in access to preventive services or healthy food options, health disparities, or the burden of chronic disease in particular areas. Implementing processes for sharing population health information and analyses with providers can inform individual patient outreach strategies and delivery system changes.

- Trillium Community Health Plan in Oregon funds a Lane County epidemiologist who works directly with the CCO's analytics department to use data to achieve the goals of prevention programs.¹⁰

5. Provider Recognition and Marketing

Public health agencies can further the integration of public health and health care through programs that recognize providers who deliver high-quality care, either for select services or to targeted groups of individuals, and then publicize entities that have earned an agency's recognition. Agencies may even consider implementing programs that extend beyond recognition to include pathways for certifying providers who meet established standards of care and then generating awareness about those providers among a targeted population.

- In Hennepin County, Minnesota, "[Better Together Hennepin](#)", a teen pregnancy prevention initiative administered by the county's health office recognizes clinics that meet certain standards for reproductive health care for adolescents, and it advertises those clinics on a website that targets teens and young adults.
- The Centers for Disease Control and Prevention (CDC) developed a curriculum for organizations interested in offering the National Diabetes Prevention Program. The CDC maintains an online registry of organizations that have successfully demonstrated that they can effectively administer the Diabetes Prevention Program. In turn, programs can promote themselves to providers, health plans, and community members as having met the CDC's requirements for delivering diabetes prevention and management care.

6. Development and Implementation of Clinical Tools and Resources

Public health agencies can work with clinical practices to develop tools for providers to use or to which they can refer individuals. Utilizing population-based information about prevalent health conditions or behaviors that impact health, public health officials can collaborate with providers to develop customized and targeted programs for a region or population.

- Vermont's Blueprint for Health program is working with CDC-funded public health experts to improve the quality of care for chronic conditions at its patient-centered medical homes. For example, patient-centered medical homes are adopting evidence-based self-management tools, developed by public health officials, into their standard of care.¹¹

Public health agencies can also create national standards for care delivery that can be adopted, as in the case of the National Diabetes Prevention Program.

7. Provider Training and Technical Assistance

Public health integration into health care delivery can also occur through provider training and technical assistance. State, local, or municipal public health authorities can work with providers to support them in achieving prevention and quality improvement goals for their patients and communities.

- New York City’s Department of Health and Mental Hygiene sought to raise awareness among clinicians of community-based lifestyle programs to which they could refer patients, and to assist practices in programming referral alerts into patients’ electronic medical records.¹²
- The Hennepin County, Minnesota teen pregnancy prevention initiative, “Better Together Hennepin” supports clinics through ongoing training and quality improvement efforts to enhance the provision of adolescent sexual and reproductive health care services.
- Supported by state public health specialists, Community Health Teams in Vermont assist providers with integrating tools and resources into a practice’s standard of care to enable patients to manage chronic conditions.¹³
- State purchasers can **leverage their managed care contracts** to compel health plans to formally coordinate with public health agencies on prevention and health promotion activities. States can also engage with public health officials on best practices and minimum requirements related to the nature and substance of such coordination agreements.
- States can **define eligibility for state grant funding opportunities** to include requirements that public health agencies and health care providers jointly apply to receive funds.
- States can **apply joint accountability expectations** to public health agencies and health care organizations for work that bridges the two fields.

State Levers to Integrate Public Health and Health Care

States can utilize the following levers to advance one or more of the public health integration techniques described above:

- State purchasing entities can **structure their reimbursement systems to pay for evidence-based programs** that have been proven to improve health and wellness. Examples of such programs include community health workers, smoking cessation programs, and community lifestyle programs.

Conclusion

State and local public health departments, and their health care provider partners, can draw on the approaches and examples described in this brief to advance their own goals of integration to improve population health. Together, public health officials, state health care purchasers, and clinicians can design reimbursement and delivery systems that are better positioned to effectively address a range of determinants of health, and focus on primary and secondary prevention efforts. By harnessing the momentum of population health management, multiple state and local agencies can play an integral role in creating a health care system that delivers comprehensive, coordinated, and integrated care to improve the health of populations.

Endnotes

- ¹ Centers for Medicare & Medicaid Services, (May 22, 2014) *State Innovation Models: Round Two of Funding for Design and Test Assistance*, <https://innovation.cms.gov/Files/x/StateInnovationRdTwoFOA.pdf>.
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- ⁴ Oregon Health Authority, *Oregon Health Plan Amended and Restated Health Plan Services Contract*, http://www.oregon.gov/oha/OHPB/docs/2015_CCO_Model_Contract.pdf.
- ⁵ Louisiana Office of Public Health, *OPH/MCO Memorandum of Understanding, Office of Public Health Memorandum of Understanding Guidelines*, <https://www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=Louisiana+Office+of+Public+Health+Memorandum+of+Understanding+MCO>.
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- ⁷ Oregon Health Authority (October 2014) Transformation Center, *Coordinated Care Organizations and Public Health Authorities in Collaboration*, <http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/Documents/success-stories/case-study-lane.pdf>.
- ⁸ Alliance of Community Health Plans (2014) *Community Health Plans: Investing in Better Care, Better Health, 2014 Report to the Community*, http://www.achp.org/wp-content/uploads/annualReport2014_ACHP_FINAL-lowres.pdf.
- ⁹ See Rocky Mountain Health Plans, *RMHP Foundation Projects*, <http://www.rmhp.org/about-rmhp/community-involvement/rmhp-foundation-projects>.
- ¹⁰ Lane County Health and Human Services Official, telephone interview with author, 09/29/2015.
- ¹¹ Department of Vermont Health Access Officials, telephone interview with author, 10/02/2015.
- ¹² NYC Primary Care Information Project Bulletin (October 2012) *Join PCIP’s South Bronx Community Referral Taskforce*, http://www.nycreach.org/pdfs/PCIP_Bulletin_October_2012.pdf.
- ¹³ Department of Vermont Health Access Officials.